Schedule of Benefits

Employer:	**Howard County Public School System**
ASA:	622787
Issue Date:	November 14, 2013
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Schedule:	2A
Booklet Base:	2

For: Open Access Aetna Select Medical Plan

Aetna Select Medical Plan

Plan Maximum Out of Pocket Limit includes plan **copayments**.

Plan Maximum Out of Pocket Limit excludes precertification penalties.

Individual Maximum Out of Pocket Limit:

- For **network** expenses: $2,000

Family Maximum Out of Pocket Limit:

- For **network** expenses: $6,000

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Lifetime Maximum Benefit per person	Unlimited	Not applicable

Payment Percentage listed in the Schedule below reflects the Plan Payment Percentage. This is the amount the Plan pays. You are responsible to pay any deductibles, co payments, and the remaining payment percentage. You are responsible for full payment of any non-covered expenses you incur.

All Covered Expenses Are Subject To The Calendar Year Deductible Unless Otherwise Noted In The Schedule Below.

Maximums for specific covered expenses, including visit, day and dollar maximums are combined maximums between network and out-of-network, unless specifically stated otherwise.

PLAN FEATURES	NETWORK	OUT OF NETWORK
Preventive Care		
Routine Physical Exams Adults only. Includes coverage for immunizations *Copay waived for lab services when physician's office visit is not charged.	$10 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Maximum exams per 12 consecutive month period Adult age 18 to 65 Maximum exams per 12 consecutive month period Adult age 65 and over	 1 exam 1 exam	 Not Covered Not Covered
Well Child Exams Includes coverage for immunizations *Copay waived for lab services when physician's office visit is not charged.	$10 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Maximum exams 24 consecutive month period Under age 2 first 12 months of life 13th-24th months of life Maximum exams per 12 consecutive month period For age 2 to 18	 7 exams 2 exams 1 exam	 Not Covered Not Covered Not Covered
Routine Gynecological Exam *Copay waived for lab services when physician's office visit is not charged.	$10 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered

Maximum exams per Calendar Year	1 exam	Not Covered
Hearing Exam	$15 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Maximum exams per 12 month period	1 exam	Not Covered
Hearing Supply Maximum per 36 month period to age 19 *(GR-9N-S-25-005-01)*	1 hearing aid per ear up to a maximum of $1,400	Not Covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Routine Cancer Screening		
Routine Mammography	100% No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Prostate Specific Antigen Test For covered males age 40 and over *Copay waived for lab services when physician's office visit is not charged.	$10 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Routine Digital Rectal Exam For covered males age 40 and over *Copay waived for lab services when physician's office visit is not charged.	$10 exam **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered

Routine Pap Smears	100% No Calendar Year **deductible** applies.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Fecal Occult Blood Test	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per Calendar Year	1 test	Not Covered
Sigmoidoscopy Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Double Contrast Barium Enema (DCBE) Age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 5 consecutive year period	1 test	Not Covered
Colonoscopy age 50 and over	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum tests per 10 consecutive year period	1 test	Not Covered
PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Family Planning Services - Female Contraceptives		
Female Contraceptives	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Vision Care		
Eye Examinations (including refraction)	$15 exam **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Maximum Benefit per 12 consecutive month period	1 exam	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Physician Services		
Office Visits to Primary Care Physician Office visits (non-surgical) to non-**specialist** *Copay waived for lab services when physician's office visit is not charged.	$10 visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Specialist Office Visits *Copay waived for lab services when physician's office visit is not charged.	$15 visit **copay** then the plan pays 100%* No Calendar Year **deductible** applies.	Not Covered
Walk-In Clinics Non-Emergency Visit	$10 visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered

Physician Office Visits - Surgery		
Physician	$10 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Specialist	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies.	Not Covered
Physician Services for Inpatient Facility and Hospital Visits	100% per visit No Calendar Year **deductible** applies	Not Covered
Administration of Anesthesia	100% No Calendar Year **deductible** applies	Not Covered
Immunizations when not part of the physical exam	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prenatal Visits	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Emergency Medical Services		
Hospital Emergency Facility and Physician	$50 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies.	Paid same as Network benefits **See Important note below*

***Important Note**: Please note that as these providers are not Network Providers and do not have a contract with **Aetna**, the provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or **physician** bills you for an amount above your cost share, you are not responsible for paying that amount. Please send **Aetna** the bill at the address listed on the back of your member ID card and **Aetna** will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.

Non-Emergency Care in a Hospital Emergency Room	Not Covered	Not Covered

Important Notice:
A separate **hospital** emergency room **deductible** or **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **deductible** or **copay** is waived.

Urgent Care Services		
Urgent Medical Care *(at a non-hospital free standing facility)*	$15 **copay** per visit then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Urgent Medical Care *(from other than a non-hospital free standing facility)*	Refer to *Emergency Medical Services* and *Physician Services* above.	Refer to *Emergency Medical Services* and *Physician Services* above.
Non-Urgent Use of Urgent Care Provider *(at an Emergency Room or a non-hospital free standing facility)*	Not Covered	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Outpatient Diagnostic Testing		
Complex Imaging Services		
Complex Imaging	100% per test No Calendar Year **deductible** applies	Not Covered
Diagnostic Laboratory Testing		
	100% per procedure No Calendar Year **deductible** applies	Not Covered
Diagnostic X-Rays		
Diagnostic X-Rays (except Complex Imaging Services)	100% per procedure No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Surgery		
Outpatient Surgery	100% per visit/surgical procedure No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Facility Expenses		
Birthing Center	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Hospital Facility Expenses Room and Board (including maternity)	100% per admission No Calendar Year **deductible** applies	Not Covered
Other than Room and Board	100% per admission No Calendar Year **deductible** applies	Not Covered
Skilled Nursing Inpatient Facility	100% No Calendar Year **deductible** applies	Not Covered
Maximum Days per Calendar Year	120 days	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Specialty Benefits		
Home Health Care(Outpatient)	100% per visit No Calendar Year **deductible** applies	Not Covered
Maximum Visits per Calendar Year	120 visits	Not Covered
Private Duty Nursing (Outpatient)	100% per visit No Calendar Year **deductible** applies	Not Covered

Maximum Visit Limit per Calendar Year	70 Private Duty Nursing Shifts. Up to 8 hours will be deemed to be one private duty nursing shift.	Not Covered

Hospice Benefits		
Hospice Care –Facility Expenses (Room & Board)	100% per admission No Calendar Year **deductible** applies	Not Covered
Hospice Care – Other Expenses during a stay	100% per admission No Calendar Year **deductible** applies	Not Covered

Hospice Outpatient Visits	100% per visit No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Infertility Treatment		
Basic Infertility Expenses Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Comprehensive Infertility Expenses Expenses for Comprehensive Infertility services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Artificial Insemination Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Ovulation Induction Maximum Benefit	6 courses of treatment per lifetime	Not Covered
Maximum per lifetime	$100,000	Not Covered
The Comprehensive Infertility services maximum per lifetime amount shown above will not be used to satisfy the plan **Maximum Out-of-Pocket Limit.**		

Advanced Reproductive Technology (ART) Expenses Expenses for Advanced Reproductive Technology (ART) services will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum per lifetime	$100,000	Not Covered
The Advanced Reproductive Technology (ART) Expenses Maximum per lifetime shown above will not be used to satisfy the plan **Maximum Out-of-Pocket Limit**.		

PLAN FEATURES	**NETWORK**	**OUT-OF-NETWORK**
Inpatient Treatment of Mental Disorders		
MENTAL DISORDERS		
Hospital Facility Expenses		
Room and Board	100% per admission No Calendar Year **deductible** applies.	Not Covered
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	Not Covered
Physician Services	100% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	100% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit No Calendar Year **deductible** applies.	Not Covered

Outpatient Treatment Of Mental Disorders		
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Inpatient Treatment of Substance Abuse		
Hospital Facility Expenses		
Room and Board	100% per admission No Calendar Year **deductible** applies	Not Covered
Other than Room and Board	100% per admission No Calendar Year **deductible** applies.	Not Covered
Physician Services	100% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses	100% per admission No Calendar Year **deductible** applies.	Not Covered
Inpatient Residential Treatment Facility Expenses Physician Services	100% per visit No Calendar Year **deductible** applies.	Not Covered
Outpatient Treatment of Substance Abuse		
Outpatient Services	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Obesity Treatment Non Surgical		
Outpatient Obesity Treatment (non surgical)	100% per visit No Calendar Year **deductible** applies	Not Covered
Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)	100% per admission No Calendar Year **deductible** applies	Not Covered
Outpatient Morbid Obesity Surgery	100% per service No Calendar Year **deductible** applies	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
Transplant Services Facility and Non-Facility Expenses			
Transplant Facility Expenses	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered
Transplant Physician Services (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Other Covered Health Expenses		
Acupuncture	100% per visit No Calendar Year **deductible** applies	Not Covered
Ground, Air or Water Ambulance	100%	Not Covered
Diabetic Equipment, Supplies and Education	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

Durable Medical and Surgical Equipment	100% per item No Calendar Year **deductible** applies	Not Covered
Maximum Benefit per Calendar Year	$10,000	Not Covered
Jaw Joint Disorder Treatment	100% per visit No Calendar Year **deductible** applies	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Prosthetic Devices	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Outpatient Therapies		
Chemotherapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Infusion Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Radiation Therapy	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Outpatient Physical and Occupational Therapy only	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered

Combined Physical and Occupational Therapy Maximum visits per Calendar Year	120 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Short Term Outpatient Rehabilitation Therapies		
Speech Therapy only	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Speech Therapy Maximum visits per Calendar Year	60 visits	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
Spinal Manipulation		
	$15 per visit **copay** then the plan pays 100% No Calendar Year **deductible** applies	Not Covered
Spinal Manipulation Maximum visits per Calendar Year	30 visits	Not Covered

Expense Provisions

The following provisions apply to your health expense plan.
This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.

Copayments and Benefit Deductible Provisions

Copayment, Copay
This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

Payment Provisions

Payment Percentage

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the "Plan Payment Percentage". Once applicable **deductibles** have been met, your plan will pay a percentage of the **covered expenses**, and you will be responsible for the rest of the costs. The payment percentage may vary by the type of expense. Refer to your *Schedule of Benefits* for payment percentage amounts for each covered benefit.

Maximum Out-of-Pocket Limit

The **Maximum Out-of-Pocket Limit** is the maximum amount you are responsible to pay for **covered expenses** during the Calendar Year. This Plan has an individual **Maximum Out-of-Pocket Limit**. As to the individual **Maximum Out-of-Pocket Limit**, each of you must meet your **Maximum Out-of-Pocket Limit** separately and they cannot be combined and applied towards one limit.

Certain **covered expenses** do not apply toward the **Maximum Out-of-Pocket Limit**. See list below.

Network Provider Maximum Out-of-Pocket Limit

Individual

Once the amount of eligible **network provider** expenses you or your covered dependents have paid during the Calendar Year meets the individual **Maximum Out-of-Pocket Limit**, this Plan will pay 100% of such **covered expenses** that apply toward the limit for the remainder of the Calendar Year for that person.

Family Maximum Out-of-Pocket Limit

When you and each of your covered dependents incur **covered expenses** that apply towards the individual Calendar Year **network provider Maximum Out-of-Pocket Limit**, these expenses will also count toward a family **network provider Maximum Out-of-Pocket Limit**.

To satisfy this family **network provider Maximum Out-of-Pocket Limit** for the rest of the Calendar Year, the following must happen:

> The family **Maximum Out-of-Pocket Limit** is a cumulative **Maximum Out-of-Pocket Limit** for all family members. The family **network provider Maximum Out-of-Pocket Limit** can be met by a combination of family members with no single individual within the family contributing more than the individual **network provider Maximum Out-of-Pocket Limit** amount in a Calendar Year.

Expenses That Do Not Apply to Your Out-of-Pocket Limit

Certain covered expenses do not apply toward your plan **out-of-pocket** limit. These include:

- Charges over the **recognized charge**;
- Expenses incurred for outpatient **prescription drugs**;
- Non-covered expenses;
- Expenses for non-emergency use of the emergency room;
- Expenses incurred for non-urgent use of an **urgent care provider**; and
- Expenses that are not paid, or **precertification** benefit reductions because a required **precertification** for the service(s) or supply was not obtained from **Aetna**.

General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.